Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON HOSPITAL FOR SPECIALIZED SURGERY
11711 N MERIDIAN ST SUITE 200
CARMEL IN 46032

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-13-3076-01

MFDR Date Received
July 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Per Texas Insurance Code – Sec. 1305.353(h) Treatments and services for an emergency do not require preauthorization."

Amount in Dispute: $8,361.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Texas Mutual declined to issue payment of the requestor's initial bill and used message modifier 225 to communicate: THE SUBMTTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2013	Outpatient Hospital Services	$8,361.67	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. 28 Texas Administrative Code §133.20 set out procedures for medical bill submission by health care provider.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED.

Issues

1. Did the respondent support the insurance carrier's reason for denying medical claim?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed surgical services with reason code 225, "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED." Review of submitted documentation finds the following;
    a. Operative Report indicates; "SURGICAL PROCEDURE: Left long finger removal of deep foreign body, code 20525.
    b. Medical claim submitted with code 29848, "Endoscopy, wrist, surgical, with release of transverse carpal ligament."

    No documentation was found to support that the submitted surgical procedure was performed therefore; the nsurance carrier's denial reason is supported.

2. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October , 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.